

Outpatient Referral Request



Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date
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Location:	Patient Type:	<input type="checkbox"/> None <input type="checkbox"/> State <input type="checkbox"/> Interstate Compact <input type="checkbox"/> Federal <input type="checkbox"/> ICE/INS
Social Security #	<input type="checkbox"/> Is Juvenile <input type="checkbox"/> Is Infirmary Housed	
Alias:	Gender:	<input type="radio"/> Male <input type="radio"/> Female
Custody Date:	Anticipated Release Date:	
Requesting Provider:	Provider Signature:	

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Workers Comp | <input type="checkbox"/> Confirmed due to Violence | <input type="checkbox"/> Suspected due to Violence | <input type="checkbox"/> Pre-Existing Condition |
| <input type="checkbox"/> Inpatient Stay | <input type="checkbox"/> Pre booking Event | | |
| <input type="checkbox"/> Pre-Sentenced | <input type="checkbox"/> Sentenced | <input type="radio"/> Not Financially Liable <input type="radio"/> Financially Liable | |

- Category of Service:**
- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Office Visit | <input type="checkbox"/> On-Site Chemo | <input type="checkbox"/> Radiation Therapy |
| <input type="checkbox"/> Off-Site Radiology | <input type="checkbox"/> Office Visit w/ Procedure | <input type="checkbox"/> Surgery | <input type="checkbox"/> Stat Lab |
| <input type="checkbox"/> Other _____ | | | |

Consulting Provider:
(Hospital, Clinic, Physician name, list all applicable): _____

Diagnosis:

Previous Treatment and Response (Include Meds):

History of Illness / Injury with date of Onset:

Results of complaint directed physical exam with findings:

Type of procedure requested:

Current functional ability / ADLs:

Other:



TRANSFER FORM



<i>Patient Name</i>	<i>Inmate Number</i>	<i>Booking Number</i>	<i>Date of Birth</i>	<i>Today's Date</i>
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Date: _____

From: _____
(Institution)

To: _____
(Institution)

Chronic Illness: _____

Last Chronic Care Clinic Visit: _____

Last TB Screen Date: _____

If past positive,

Result: _____

Last CXR: _____

Result: _____

Activity Limitations (check):

- ☐ Bottom bunk
- ☐ Crutches
- ☐ Wheelchair
- ☐ Blind
- ☐ Other: _____

Serious Allergy: _____

Pending Consultations/Outside Appointments: _____

Current Medications: _____

Name of Person Completing Form/Title: _____

Signature _____

